COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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February 13, 2018

Mr. Randy Ricker
Vice-President, Managed Long Term Services and Supports
Optima Community Health Plan
4417 Corporation Lane
Virginia Beach, Virginia 23462

Re: CCC Plus Program – Corrective Action Plan

Dear Mr. Ricker:

We believe Optima Community Care (Optima) and the Department of Medical Assistance Services (DMAS) share a common goal which is to ensure Medicaid recipients enrolled in the Commonwealth Coordinated Care Plus (CCC Plus) program receive effective, quality and timely health care. To achieve that goal, Optima's role is to provide care coordination with the member, work collaboratively with providers to issue authorizations for care, and process claims timely. The Department's responsibility is to monitor health plan performance with Contract standards, including quality of care, reporting, and payment to providers.

The Department has conducted weekly CCC Plus implementation calls since August 2017 with Optima's operational staff, including monitoring implementation performance through review of the weekly dashboard; identifying and discussing issues; and, tracking issues to resolution. Throughout the past six (6) months, Optima has remained engaged in these monitoring activities and committed to resolving identified issues.

Despite this effort, there are five (5) areas where Optima's performance is not within Contract standards. See Attachment 1 for a full description of each of these areas, the related Contract requirement(s), and the areas that Optima must address in its Corrective Action Plan (CAP) to comply with these Contract standards.

Optima's written CAP for all five (5) areas listed in Attachment 1 of this letter must be provided to the Department for approval no later than February 28, 2018. Failure to comply with the approved CAP will result in additional sanctions.

If you have any questions regarding these concerns, Contract standards or CAP requirements, please let me know.

Sincerely,

Tammy J. Whitlock

Tammy J. Whitlock, MSHA
Director, Integrated Care
Department of Medical Assistance Services

Attachments

ATTACHMENT 1 – AREAS FOR CORRECTIVE ACTION

AREA #1 – UNRELIABLE AND INACCURATE DASHBOARD DATA

At the inception of CCC Plus in August 2017, DMAS began holding weekly implementation meetings with all CCC Plus contracted health plans, including Optima to discuss a multitude of operational areas as it related to the early implementation activities. As part of these meetings, DMAS required Optima to submit a weekly implementation dashboard. Optima reported in early September 2017 that the data on the submitted dashboard was unreliable and inaccurate. In subsequent discussions from September to December 2017 with Optima leadership, Optima reported there was a major systems configuration issue that would involve significant systems reconfiguration. This work began in October; however, to date, Optima's system has yet to supply accurate enrollment, Health Risk Assessment (HRA) completion data, or authorization information per the CCC Plus contract requirements.

DMAS utilizes the information reported by health plans to monitor enrollment trends and Health Risk Assessment completion rates. This is a critical monitoring element utilized to ensure the most vulnerable members (including technology assisted members, children receiving private duty nursing, and other CCC Plus Waiver enrollees) have had their needs assessed and plans of care developed to ensure those needs are met. Service authorization information reported on the dashboard provides DMAS with assurances that continuity of care authorizations for private duty nursing and other agency and consumer directed services are being authorized. This monitoring has the benefit of preventing future issues related to a lack of authorizations. Additionally, DMAS compiles the data reported on the dashboard in order to look at trends and side-by-side comparisons of health plan performance.

CONTRACT REQUIREMENTS

Contract Requirement (2017 and 2018):

SECTION 17.0 REPORTING REQUIREMENTS

Section 17.1 General Requirements

Consistent with Federal and State guidelines, the Contractor shall be responsible for robust and transparent reporting on critical elements of CCC Plus covered services and the Contractor's major systems. The Contractor shall have adequate resources to support CCC Plus program reporting needs as required by this Contract. Examples of data to be included in reports shall include, but are limited to, behavioral health, pharmacy LTSS, claims service authorizations, provider networks, grievances and appeals, quality, program integrity, expenditures related to rebalancing efforts (institutional vs. community based), call center statistics (broken out by behavioral health including crisis calls and all other service categories), timeliness of assessments, individualized care plans and care plan revisions, participant health and functional status, marketing, outreach, and training, high-utilizer intervention activities, under-utilization analysis with reasons, appointment assistance activities, value based payment activities and related dashboards.

CORRECTIVE ACTION NEEDED

Optima must document and implement a CAP to bring this reporting requirement into compliance with contract standards. Optima's CAP must include the following information:

- A project plan including deliverables, milestones and due dates to reconfigure this system to ensure accurate reporting including the go-live date. (Due 2/28/18)
- Submit a weekly update to this project plan to DMAS for monitoring progress. (Due close of business each Tuesday, starting 2/28/18)

AREA #2 – UNTIMELY CLAIMS PAYMENT

Claims processing has been an area of focus in DMAS' efforts to monitor the successful implementation of CCC Plus. Timely claims payment within fourteen (14) days is a contractual requirement for certain claim types. Delayed payments may create a risk where providers may suspend services to members, thereby having a direct negative impact on members and the CCC Plus program. Over the past four (4) months, DMAS has noted an increasing number of claims paid outside the contractual standard and, as a result, experienced a greater number of provider calls expressing complaints and concerns. Please see the Attachment 2 for a trend analysis of Optima's untimely claim payments.

CONTRACT REQUIREMENTS

Contract Requirement (2017)
Section 12.4 PROVIDER PAYMENT SYSTEM
12.4.2 Exceptional Processing and Payment Rules for Nursing Facility, LTSS, ARTS, and Early Intervention (page 178)
1. The Contractor shall ensure clean claims from Nursing Facilities, LTSS (including when LTSS services are covered under ESPDT), ARTS and Early Intervention providers are processed within fourteen (14) calendar days of receipt of the clean claim, as clean claim is defined in this contract, for covered services rendered to covered Members who are enrolled with the Contractor at the time the service was delivered.

Contract Requirement (2018):
SECTION 12.0 PROVIDER SERVICES AND CLAIMS PAYMENT
12.4.2 Exceptional Processing and Payment Rules for Nursing Facility, LTSS, ARTS, CMHRS and Early Intervention (page 196)
1. The Contractor shall ensure clean claims from Nursing Facilities, LTSS (including when LTSS services are covered under ESPDT), ARTS, CMHRS and Early Intervention providers are processed within fourteen (14) calendar days of receipt of the clean claim, as clean claim is defined in this contract, for covered services rendered to covered Members who are enrolled with the Contractor at the time the service was delivered.

CORRECTIVE ACTION NEEDED

Optima must document and implement a CAP to bring provider claims payment into compliance with contract standards. Please ensure the CAP includes the following information:

- A project plan or a list of deliverables, milestones and due dates to address any claims backlog or systems issue that is preventing timely claims processing. (Due 2/28/18)
- A weekly aging report showing the date of receipt of pended claims, by category as specified on the dashboard. (Due close of business each Tuesday, starting 2/28/18)
- The project plan or list of deliverables must address the claims aging report and strategies for addressing any backlog. (Due 2/28/18)
- A weekly update to this project plan to DMAS for monitoring progress. (Due close of business each Tuesday, starting 2/28/18)

AREA #3 – FAILED FILE TRANSFERS TO PPL

DMAS actively monitors file transfers between the CCC Plus health plans and the Fiscal Employer Agent, Public Partnerships, LLC. It is important that files are sent and loaded consistently in order to ensure timely payment to attendants. This continues to be an area in which Optima has difficulty. Between December 1, 2017 and January 30, 2018, Optima had twelve (12) files sent to PPL error out or be rejected for XML coding errors. The errors vary and have been a result of one or more of the following:

- The 'ParticipantDOB' element is invalid;
- The 'MedicaidID' element is invalid;
- The 'ParticipantSSN' element is invalid;
- The 'EligibilityEnd' element is invalid; and
- The 'AuthDateTo' element is invalid.

CONTRACT REQUIREMENTS

Contract Requirement (2017):

4.7.6.2 Contractor Database and Automated Systems

The Contractor shall have an automated system that has the capacity to exchange files with the Department's F/EA to verify Service Authorizations, Patient Pay, Medicaid eligibility, Program eligibility, pay rates, and other necessary data to ensure accurate payroll.

4.7.6.3 Service Authorizations

The Contractor shall electronically submit Service Authorizations (SAs) that are associated with new or updated SAs for Consumer-Directed Services. These SAs are the authorizations to the F/EA that either services have been approved for the CCC Plus Waiver Member to receive CD Services, or existing services have been changed, canceled or ended based on SA activity.

Contract Requirement (2018):

4.7.6.2 Contractor Database and Automated Systems

The Contractor shall have an automated system that has the capacity to exchange files with the Department's F/EA to verify Service Authorizations, Patient Pay, Medicaid eligibility, Program eligibility, pay rates, and other necessary data to ensure accurate payroll.

4.7.6.3 Service Authorizations

The Contractor shall electronically submit Service Authorizations (SAs) that are associated with new or updated SAs for Consumer-Directed Services. These SAs are the authorizations to the F/EA that either services have been approved for the CCC Plus Waiver Member to receive CD Services, or existing services have been changed, canceled or ended based on SA activity. The Contractor shall bear all financial risks associated with improper payment when the Contractor does not update a SA when a Member is no longer eligible. This includes brief periods of ineligibility for temporary in-patient stays. The F/EA shall not be held responsible for these payments.

CORRECTIVE ACTION NEEDED

Optima must document and implement a CAP to bring file transfers to the PPL into compliance with the contract standards. Please ensure the CAP includes the following information:

- A project plan or a list of deliverables, milestones and due dates to correct the file transfer to PPL. (Due 2/28/18)
- A weekly update to this project plan to DMAS for monitoring progress. (Due close of business each Tuesday, starting 2/28/18)

AREA #4 – LACK OF GENERATING TIMELY CONTINUITY OF CARE AUTHORIZATIONS

In October 2017, DMAS was notified that continuity of care authorizations had not been consistently generated by Optima. There were multiple reports of delays by Optima to issue continuity of care authorizations and of providers being required to submit clinical information to receive a continuity of care authorization. Additionally there were reports that non-par providers have not routinely received written notice of continuity of care authorizations from Optima. Optima's delay in or lack of generation of service authorizations has resulted in delayed billing by providers. Many providers were waiting for an authorization number from Optima prior to submitting the claim. Providers have received claim denials from Optima due to the lack of an authorization during the continuity of care period. The most heavily impacted providers are those providing personal care or private duty nursing. Providers have expressed significant concerns, including that they have considered suspending services to members due to lack of authorizations and claim denials.

CONTRACT REQUIREMENTS

Contract Requirement (2017 and 2018):
5.15.10 Continuity of Care
The Contractor shall submit policies and procedures that reflect how the Contractor will meet the requirements stated in this Contract related to all continuity of care provisions, and:

1) How the Contractor will automatically generate service authorizations for continuity of care for Members whose authorization information is included in the MTR file received from the Department prior to enrollment and how this information is disseminated internally and to whom.
2) How the Contractor will notify Members and providers in writing of the continuity of care authorization, including the service or item, name of the provider, authorized units or amounts, and authorized dates of service.
3) How the Contractor will ensure Medically Necessary services are continued without gaps in care at the end of the continuity of care period and the role of the care coordinator to ensure services needed on an ongoing basis do not lapse.
4) Outreach efforts to non-participating providers and pharmacies to ensure services are not discontinued during the continuity of care period.

CORRECTIVE ACTION NEEDED

Optima must document and implement a CAP to bring continuity of care processes into compliance with contract standards. Please ensure the CAP includes the following information:

- A project plan or a list of deliverables, milestones and due dates to correct and automate the timely generation of continuity of care authorizations. (Due 2/28/18)
- A project plan or a list of deliverables, milestones and due dates to ensure that written notification is provided to members and providers, inclusive of all required information for all continuity of care authorizations per contract standards. (Due 2/28/18)
- A weekly update to this project plan to DMAS for monitoring progress. (Due close of business each Tuesday, starting 2/28/18)

AREA #5 – UNTIMELY PAYMENT OF SPECIALIZED CARE CLAIMS

During the nursing facility claims workgroup, which started in July 2017 and included participation from all CCC Plus plans, the consensus of the group was that all CCC Plus health plans would accept and process specialized care claims using the 199 revenue code with the 65x bill type. In early January 2018, it was reported that Optima's clearinghouse, Availity, was rejecting all specialized care claims. This issue has resulted in providers being unreimbursed for these services. Accounts receivables are mounting, creating a hardship for these providers. Members are at risk for losing the medically necessary specialized care due to non-payment to the provider by Optima.

CONTRACT REQUIREMENTS

2017 & 2018 Contract Requirement:

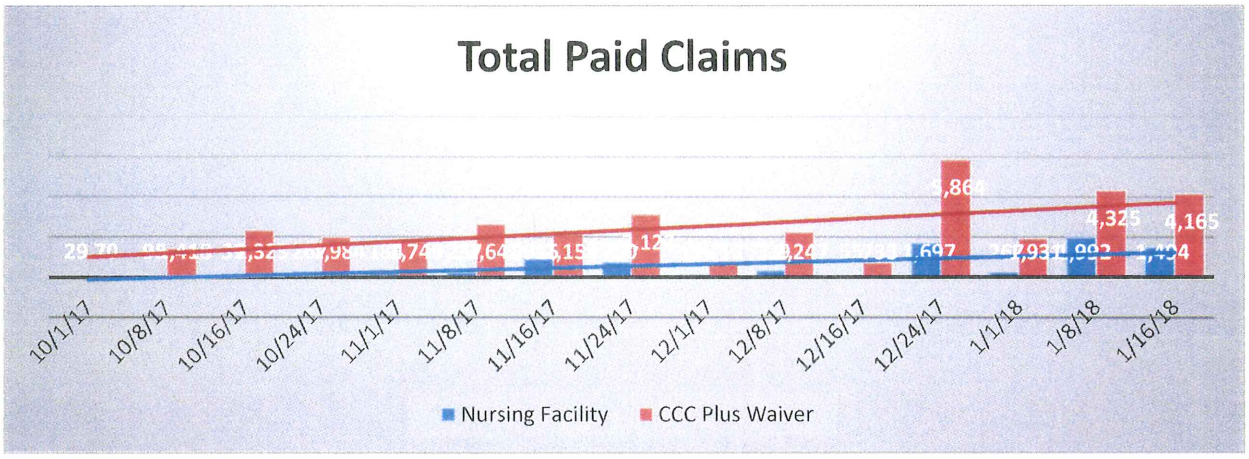
12.4.4 Electronic Submission

The Contractor shall make available to providers an electronic means of submitting claims. In addition, the Contractor shall make every effort to assure at least sixty (60%) percent of claims received from providers are submitted electronically.

CORRECTIVE ACTION NEEDED

Optima must document and implement a CAP to bring electronic claims submission into compliance with the contract standards. Please ensure the CAP includes the following information:

- A project plan or a list of deliverables, milestones and due dates to correct, successfully accept, and process specialized care claims. (Due 2/28/18)
- A weekly update to this project plan to DMAS for monitoring progress. (Due close of business each Tuesday, starting 2/28/18)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4,165
10/1/17
10/8/17
10/16/17
10/24/17
11/1/17
11/8/17
11/16/17
11/24/17
12/1/17
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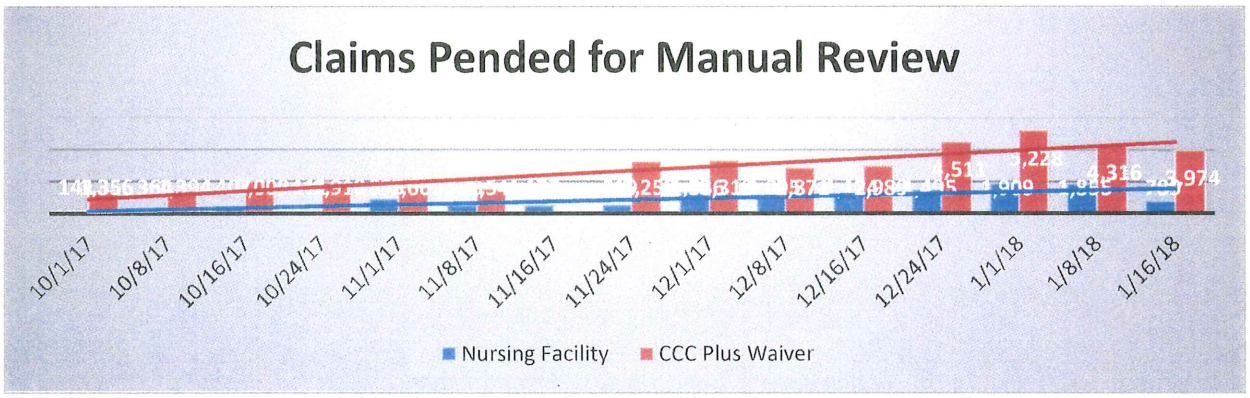
12/24/17
1/1/18
1/8/18
1/16/18
Nursing Facility
CCC Plus Waiver


Claims Pended for Manual Review
4,316
10/1/17
10/8/17
10/16/17
10/24/17
11/1/17
11/8/17
11/16/17
11/24/17
12/1/17
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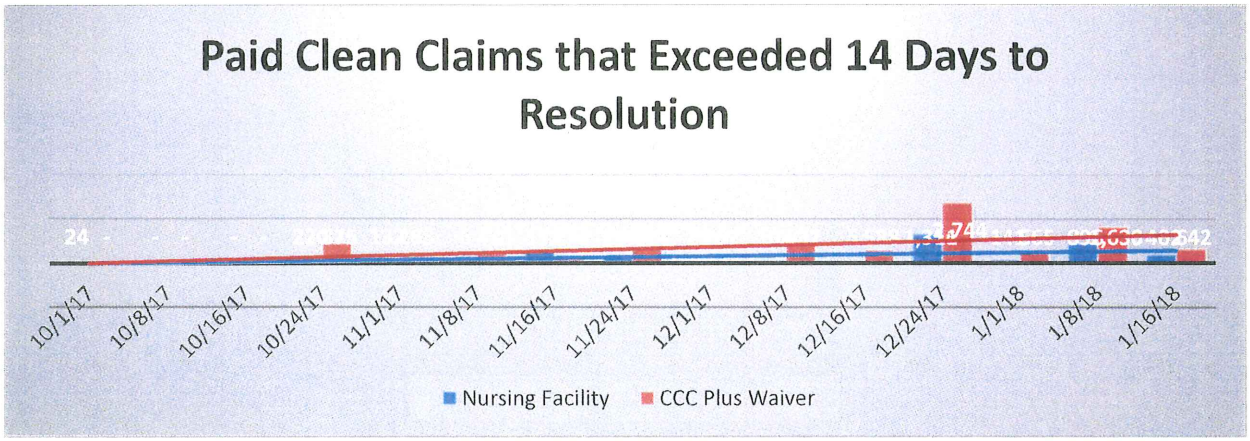
1/8/18
1/16/18
Nursing Facility
CCC Plus Waiver


Paid Clean Claims that Exceeded 14 Days to Resolution
24
10/1/17
10/8/17
10/16/17
10/24/17
11/1/17
11/8/17
11/16/17
11/24/17
12/1/17
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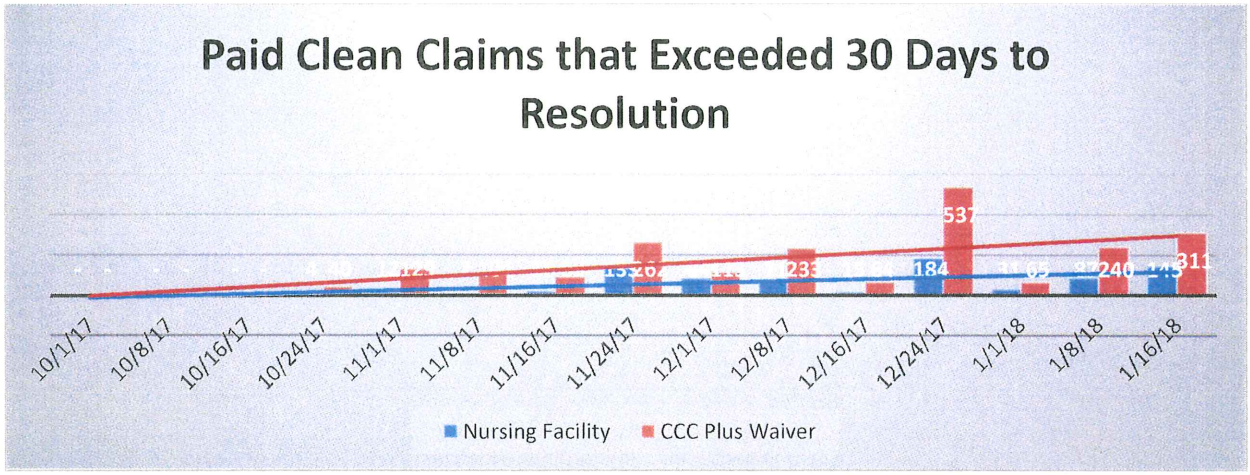
1/8/18
1/16/18
Nursing Facility
CCC Plus Waiver


Paid Clean Claims that Exceeded 30 Days to Resolution
10/1/17
10/8/17
10/16/17
10/24/17
11/1/17
11/8/17
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11/24/17
12/1/17
12/8/17
12/16/17
12/24/17
1/1/18
1/8/18
1/16/18
Nursing Facility
CCC Plus Waiver